Beech Lawn Care Limited

Beech Lawn Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection on 14 and 15 October 2015. Beech Lawn Nursing and Residential Home provides nursing and residential care for up to 44 older people who require support in their later life or are living with dementia.

There were 35 people living at the service at the time of our inspection. The service is on two floors, with access to the upper floors via stairs, chair lift, or wheel chair lift. Some bedrooms have en-suite facilities which have a toilet and wash basin. There are shared bathrooms, shower facilities and toilets. Communal areas include two lounges, and three dining rooms. There is an outside patio area with seating. The care home is a short walk from the main town and shops.

The service had a registered manager in post. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in November 2014 we told the provider to take action to make improvements to how they ensured people consented to their care, how the quality of the service was monitored, and how records relating to people's care were documented and kept confidential. Improvements were also required to ensure the management of medicines was safe, people's human rights were protected by the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards, training and supervision of staff was undertaken, safe recruitment process were followed, and systems were in place to protect people from avoidable harm or abuse. The provider sent us an action plan confirming how improvements were going to be made and advising us that these improvements would be completed by May 2015. On 18 May 2015 the provider confirmed the action plan had been completed and requested a follow up inspection. During this inspection we looked to see if these improvements had been made. We found they had not all been completed.

People told us staff were kind and caring, and treated them with respect. Relatives told us they were happy with the care their loved ones received. People and their relatives told us there were not always enough staff. There were nursing vacancies at the service and the registered manager had been covering shifts which had impacted on the management of the service. Social activities were limited which meant some people did not have much to occupy themselves.

People were supported to eat and drink enough and maintain a balanced diet. The chef was knowledgeable about people's individual nutritional needs. People who required assistance with their meals were supported in a kind way. People's care plans did not always provide detail to staff about how to meet people's individual nutritional needs. People were at risk from staff not knowing if they had lost weight, because people's weights were not reviewed and some people were not being weighed.

People felt safe. The registered manager and staff understood their safeguarding responsibilities and had undertaken training. People did not always have a call bell in reach to alert staff if they needed assistance. People were protected by safe recruitment procedures as the registered manager ensured new employees were subject to necessary checks which determined they were suitable to work with vulnerable people.

People were not protected from risks associated with their care because staff did not have the correct guidance and direction about how to meet people's individual care needs. Accidents and incidents were not robustly analysed to help prevent them from occurring again. People did not always have a personal evacuation plan in place, which meant people may not be effectively supported in an emergency. People's specialist equipment, which was in place to meet their individual needs, was not always effectively monitored to ensure it was working correctly.

People's mental capacity was not always being assessed which meant care being provided by staff may not have always been in line with people's wishes. People who may have been deprived of their liberty had not always been assessed. The registered manager and staff did not fully understand how the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) protected people to ensure their freedom was supported and respected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's consent to care and treatment had been obtained and recorded in their care plans. Staff asked people for their consent prior to supporting them.

People did not always have care plans in place to address their individual health and social care needs. People's care plans were not always reflective of the care being delivered. People were not involved in the creation of their care plan. People's preferences for getting up and going to bed, were not recorded so staff were unaware of what people's wishes were. People's care plans to minimise the risk of pressure sores were not always followed. Care records in relation to nursing care were not always reflective of people's care plans. People's

Summary of findings

changing care needs were referred to relevant health services. External health professionals did not have any concerns and explained they were contacted appropriately when required.

People's end of life wishes were documented and communicated. This meant people's end of life wishes were known to staff. People's medicines were managed safely.

People's confidential and personal information was stored securely and the registered manager and staff were mindful of the importance of confidentiality when speaking about people's care and support needs in front of others.

People living with dementia were not always appropriately supported in a person centred way. People's care plans did not address dementia care needs and demonstrate how they would like to be supported.

People told us if they had any concerns or complaints they felt confident to speak with the staff or registered manager. People were being asked if they would like to attend residents meetings to provide their feedback about the service, and to help ensure the service was meeting their needs as well as assisting with continuous improvement.

People received care from staff that had been given training and supervision to carry out their role. However, nursing staff had not been formally supervised because the registered manager had not had time. Staff felt the registered manager was supportive. Staff felt confident about whistleblowing and told us the registered manager would take action to address any concerns

The registered manager was unable to manage the service effectively because there were not enough nursing staff. The registered manager did not receive effective support from the provider.

The registered manager did not have effective systems and processes in place to ensure people received a high quality of care and people's needs were being met.

The Commission was notified appropriately, for example in the event of a person dying or experiencing injury. The registered manager had apologised to people when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People told us there were not always enough staff to meet their needs.

People were not protected from risks associated with their care and documentation relating to this was not always in place, and did not always reflect people's individual needs.

People told us they felt safe. Staff knew what action they would take if they

suspected abuse was taking place. Safe recruitment practices were in place.

People were given their medicines in a safe way.

Is the service effective?

Requires improvement

The service was not always effective.

People were not protected by the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) which meant people's freedom was not always supported or respected.

People received support from staff who had the necessary knowledge, skills and training to meet their needs. Care staff received supervision; however nursing competence was not being assessed.

People's consent was obtained in respect of their care and treatment.

People liked the food, and were supported to eat and drink enough and maintain a balanced diet.

People's changing care needs were referred to relevant health services.

Is the service caring?

Good

The service was caring.

People were not always actively involved in their care plan reviews which meant they may not be reflective of their wishes and preferences; however the registered manager was taking action to address this.

People told us staff were kind.

Staff spoke fondly of people and knew people well.

People's privacy and dignity were respected.

People were cared for at the end of their life. Nursing staff had good links with GPs to help ensure people's care was effectively co-ordinated.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People were not involved in the design and implementation of their own care

plan which meant care planning documentation was not reflective of their wishes.

People's care plans were not individualised and did not always give guidance and direction to staff about how to meet people's care needs.

People's independence and social life were promoted, but social activities were limited which meant some people had very little to occupy their time.

People could raise concerns and complaints. People felt confident action would be taken.

Is the service well-led?

Requires improvement 

The service was not always well led.

People did not receive a high standard of quality care because the systems and processes for quality monitoring were ineffective in ensuring people's individual needs were safely met.

The registered manager monitored incidents and risks; however the system in place was not robust in ensuring the care provided was safe, effective and responsive.

The registered manager was unable to manage the service effectively because she had been working as a nurse, as there were not enough nursing staff.

The registered manager did not receive effective support from the provider.

People and staff were encouraged to provide feedback about the running of the service.

The registered manager worked with external professionals to help ensure people's health care needs were met.

Beech Lawn Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the home unannounced on 14 and 15 October 2015. The inspection team consisted of two adult social care inspectors, a pharmacy inspector, and an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the home. We reviewed notifications of incidents that the provider had sent us since the last inspection and previous inspection reports. A notification is information about important events, which the service is required to send us by law. We also contacted the local authority commissioners and service improvement team and Healthwatch Cornwall for their views.

During our inspection we spoke with 11 people living at the care home, six relatives/visitors, eight care staff, two nurses, two chefs, one kitchen assistant, a maintenance man, the administrator, the deputy manager, the registered manager and the registered provider.

We observed care and support in communal areas, and watched how people were supported during lunch. We spoke with people in private and looked at five care plans and associated care documentation. We pathway tracked two people who lived at the home. Pathway tracking is where we follow a person's route through the service and capture information about how they receive care and treatment. We also looked at records that related to people's medicines, as well as documentation relating to the management of the service. These included policies and procedures, audits, staffing rotas, three staff recruitment files, training records and quality assurance and monitoring paperwork. We assessed and reviewed the safety and cleanliness of the environment.

After our inspection we requested feedback from a speech and language therapist, a dementia liaison nurse, a continuing health care nurse, and a GP practice to obtain their views.

Requires improvement

Is the service safe?

Our findings

At our last inspection in November 2014 the system in place to assess and manage risks to people's health, safety and welfare was not always effective, records were not always stored confidentially, medicines were not always being managed safely and safe recruitment processes were not always followed. The provider sent us an action plan detailing how they would make improvements. At this inspection we found the provider had made some improvements, however further improvements were required.

People's falls and accidents were recorded. However, the information about people's accidents and falls was not being robustly recorded and effectively being used to identify themes to help keep people safe, and prevent them from happening again. For example, one person had fallen in July 2015, however the provider's audit had not identified this.

People's risk assessments, that give guidance to staff about how to minimise associated risks related to people's individual care needs, were not always in place. For one person, who had recently moved into the care home and had fallen in September 2015, there were no care plans or risk assessments in place. When risk assessments were in place, they had not always been updated and reviewed effectively. One person had fallen in July 2015, the person's care plan had been reviewed in September 2015, but there had been no recognition of the fall, and no care plan or risk assessments subsequently put into place.

We found risk assessments were not always in place as necessary, updated, and reviewed effectively. Risk assessments were not always reflective of people's individual needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's personal evacuation needs had been documented but these had not been updated recently, which meant in the event of a fire emergency services may not know what level of care and support people may need. The registered manager told us she had not had time to do this.

People's equipment was not always being checked to ensure it met their individual needs. Daily checks of specialist airflow mattresses were in place. This was to make sure the setting was correct for the person's weight and to minimise the likelihood of a person suffering skin damage. For one person their mattress had not been correctly set and their daily checks had not been consistently carried out. After this had been identified, a nurse adjusted the setting. The nurse explained they tried to make checks daily; however, the registered manager admitted there was no system in place for monitoring to check these were taking place.

People's comments about whether there were enough staff were variable. Whilst some comments were positive, "As far as I can see there's always plenty of staff around", one person told us, "Sometimes they're in an awful rush, especially going to bed. Everything is double quick…. It just feels rushed, going to bed. It's feet up, covered up, light off. But they've got so many to deal with".

Relatives told us, "I think they are a bit stretched at lunchtime so I come and help […]" and "I can be here about an hour sometimes and don't see anybody".

During our inspection people were supported by adequate staff, and staff were not rushed. However, staff were often too busy and focused on carrying out essential tasks to stop and talk with people. The registered manager explained she was in the process of researching a staffing dependency tool to calculate the required staffing, and to help ensure and demonstrate there were enough staff to meet people's individual needs.

There were provider had two nursing vacancies at the care home and this had been the case for some time. The registered manager had been covering these shifts and agency nurses were being used to cover some night shifts. As a result of this, the registered manager had been unable to carry out effective management of the care home and explained the impact this had been having, for example supervising staff. The provider told us four nurses had been identified for interview and would hopefully be recruited soon. The provider was in the process of re-devising the staffing structure at the care home which he felt would be beneficial to the management of the service.

People told us there were not always enough staff to meet their needs. There were not sufficient numbers of nursing staff deployed which impacted on the management of the service. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service safe?

People had call bells in place and used them to call for assistance, people told us they did not have to wait long. One person told us, "I've never had to wait long for staff to come when I call" and "If there are no staff about its easy enough to call one". However, we observed two people's call bells were out of their reach, and one person told us, "I get frustrated because my call bell is out of reach and they don't like you shouting out". We spoke with the registered manager about what we had observed and the person's comment; they confirmed they would speak with the person immediately and take any necessary action.

People's personal confidential records were locked away when not in use. People's money, when held by the provider, was kept secure. However, the list of financial transactions both in and out, were not always clear which made auditing the money difficult. The administrator explained they would take action to address this immediately.

People were given their medicines in a safe way, one person told us, "I always get my medicine at 11 o'clock in the morning and 6 o'clock at night, no problem". Medicines were stored safely and at appropriate temperatures. There were suitable arrangements for the storage, recording and handling of controlled drugs, and regular checks were undertaken by staff.

People told us they felt safe. The registered manager and staff were able to tell us about what action they would take if they suspected abuse was taking place. Staff told us they would have no hesitation in reporting it to the registered manager or to the provider. They confirmed they had access to the relevant policy which helped ensure they followed the correct procedures.

People were protected by safe recruitment procedures. The registered manager followed their policy which ensured all employees and volunteers were subject to necessary checks to determine they were suitable to work with vulnerable people. Agency staff working within the care home were provided with essential information. This helped to keep people safe, and ensure they knew the correct action to take in an emergency, for example fire evacuation procedures for the care home.

There was a system in place to ensure equipment was serviced in line with manufacturing guidelines so that it was safe for people to use. Documentation showed equipment was well maintained, for example moving and handling equipment and the fire system.

Requires improvement

Is the service effective?

Our findings

At our last inspection in November 2014 people had not always consented to their care, people's humans rights were not always protected by the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS) and staff did not always receive training and supervision. The provider sent us an action plan detailing how they would make improvements. At this inspection we found the provider had made some improvements, however further improvements were required.

People's mental capacity was not always being assessed which meant care being provided by staff may not always be in line with people's wishes. The legislative framework of the Mental Capacity Act 2005 (MCA) was not always being followed. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made

involving people who know the person well and other professionals, where relevant. For example, one person had recently fallen and to prevent this from happening again, it had been recorded bed rails should be in place. However, there was no evidence of how this decision had been made, taking into account the person's mental capacity and there was no record of a "best interest" meeting. Another person who remained in bed told us they felt "trapped" by their bed rails and felt it was because staff did not want them to leave. There were no details in this person's care plan about how the decision for this person to remain in bed, with bed rails had been reached.

Some people were living with dementia. People's care plans did not always contain guidance and directions for staff about how to support people when they did not have the capacity to make decisions for themselves.

People who may be deprived of their liberty had not been assessed, which meant their human rights may not be protected. The deprivation of liberty safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager told us she was aware of this but had not had the time to make all of the applications which were required. The registered manager and care staff were not confident about the principles of the MCA and DoLS and some staff had not received training. Before the end of our inspection the registered manager had taken action to arrange training for herself.

People's mental capacity was not always being assessed. The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not being followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's consent was obtained prior to staff providing support, for example, a member of staff asked one person if they would like an apron on. The person replied they would, but added they did not want it fastened around their neck; staff respected the person's wishes. Consent to care and treatment had been recorded in people's care plans. One person told us they were consulted about what support they wanted on a daily basis. We saw a photograph of them in their care records and they told us they had agreed to their photograph being taken. Their care plan also included comments such as "involve chiropodist with [the person's] consent".

People's weight was not always being monitored to help ensure people were not losing excessive weight, for example weights were obtained, but there was no analysis of the information. People who were unable to stand or sit on scales did not have their weight monitored. The registered manager told us new documentation was being introduced to incorporate the malnutrition universal screening tool (MUST). This tool is used to measure a person's weight by a calculation of a person's BMI. People had food and fluid charts in place if there were concerns about how much a person was eating and drinking. Although these charts were being completed, it was not clear how these charts were being monitored to highlight concerns. The registered manager was introducing new audits which she told us would help with this.

People with specific nutritional needs were supported effectively and external professional advice had been followed. For example, one person had a diagnosis of diabetes. The person told us they ate a low sugar diet, and explained staff always remembered this. Staff told us meals were made using sweetener in place of sugar so people could enjoy the same pudding as others. Another person had a liquidised diet following advice from a speech and language therapist. A risk assessment was in place

Requires improvement

Is the service effective?

identifying the person was at risk of choking, and provided guidance for staff on how to support the person to eat safely. We saw a member of staff provide support to the person at lunchtime and the support given was reflective of the person's care plan.

People told us the food was nice, comments included, "We have a brilliant cook", "The food is fantastic, I've even put a bit of weight on", and "We have three options every meal". One person told us they had trouble with their dentures (despite attention from a relevant professional) and so found meat difficult to chew. They described the cooks as "Very good", telling us they minced their meat so they could eat it more easily, adding "They're very good about things like that." A relative told us, "My […] has always loved his food and he always polishes it off". People were able to eat their meals in private or in the shared dining rooms.

People were supported to eat and drink enough and maintain a balanced diet. The chef and staff were knowledgeable about people's individual nutritional needs. People were given a variety of choices from a menu but were also able to request alternatives. The chef explained people were asked the day before what they would like to eat. For people who lived with dementia, this process may not be suited to meeting their needs, as people may forget what they have ordered. There were no visual prompts for people to remind them of what was for lunch and the menu was not displayed.

People's changing care needs were referred to relevant health services. People's care records demonstrated a variety of health care professionals were contacted as necessary, for example, opticians, chiropodists, and speech and language therapists. The registered manager told us they tried to encourage people to get out into the community for such appointments rather than people being confined to the care home. A GP visited twice weekly to help with people's continuity of care.

People received care from staff that had the knowledge and skills to carry out their roles and responsibilities effectively. New staff completed an induction programme. The registered manager was aware of the new 'care certificate'. The care certificate is a national induction tool which providers are required to implement, to help ensure staff work to the desired standards expected within the health and social care sector. Staff were asked to complete and update training applicable to their role, for example dementia training and manual handling. However, training records showed the maintenance man had not completed training such as fire and safeguarding. This was discussed with the registered manager who told us the provider took responsibility for the maintenance man's supervision and training.

Staff told us they felt supported and received supervision. Nursing staff had not received supervision or had their ongoing competence assessed in areas they were responsible for. The registered manager recognised this needed to happen, but told us it had not been carried out because they had not had time. Supervision is a process by which a person reflects on their work performance and identifies training and development needs.

Good

Is the service caring?

Our findings

People received care from staff who were kind and caring. Staff knew people well. People told us, "[…] makes me laugh every day, there's never a dull moment with […]", and "They have never raised their voice to me and I don't hear any raised voices". Relatives told us, "They're very cheerful" and "It's nice to hear staff come in and say my […] name".

Cards of thanks had been received from families who wanted to express their appreciation for the care provided to their loved ones, comments included, "Thank you so much for all the care and love you gave my mother", "Thank you so much for the wonderful care you gave to mum…thank you also for always making me feel so very welcome and for the endless cups of tea and coffee, you made mum's last month so happy".

Staff spoke fondly of people and knew the little things that meant so much, for example a member of staff told us, "I make it strong as I know she likes 'builder's' tea". It was important for another person to have their teddies in view, so staff made sure they were always positioned so they could see them. Staff told us how they showed kindness towards people, one member of staff told us, "You treat people as you want to be treated yourself or a family member". One member of staff did not speak as kindly about people; we spoke with the registered manager about this, who told us she would take action to address this.

People's families were welcome at any time; we saw in the visitor's book a relative had visited at 7.30am. The registered manager made sure families who lived many miles away were kept up to date about their relative's care, either by telephone or by email.

People's privacy and dignity were respected, doors and curtains were closed when people were being supported with personal care and staff knocked on people's doors prior to entering. The registered manager and staff were mindful of the importance of confidentiality when speaking about people's care and support needs in front of others.

People's care plans had a short summary of who they were, and detailed information about their past history. This helped staff get to know each person and understand what was important to them.

Residents meetings were held to obtain people's feedback about the running of the service. For example, the registered manager told us a meeting would be used to ask people about the menu.

People had access to individual support and advocacy services, for example Independent Mental Capacity Assessors (IMCA). This helped ensure the views and needs of the person concerned were documented and taken into account when care was planned.

People's end of life care had been recorded so staff knew what people's wishes were at the end of their lives. However, care plans were not personalised, and only focused on the essential tasks of nursing care and support. The registered manager told us she would be making improvements. Nursing staff worked closely with GPs when people were at the end of their life, to help ensure a co-ordinated approach was taken and people were not in any unnecessary pain. Nursing staff had been trained in the verification of death.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in November 2014 people's care records were not always reflective of people's needs and did not provide guidance and direction to staff about how to meet people's needs.

The provider sent us an action plan detailing how they would make improvements. At this inspection we found the provider had made some improvements, however further improvements were required.

People and/or their families were not involved in their care plan reviews, so were unable to be actively involved in decisions about their care and treatment, one relative told us, "I didn't know we were allowed to read my relative's care plan until you just told me, I thought it was just for the staff". The registered manager told us she would take action to address this. This contradicted the provider's care planning policy which stated, "a care plan will never be made without the active participation of the person".

People did not always have a care plan in place to provide guidance and direction to staff about how to meet their needs. For example, one person had moved into the care home at the beginning of September 2015 but a care plan was still to be devised. The registered manager had been unaware of this.

People's care plans were not individualised and did not always give guidance and direction to staff about how to meet people's care needs. For example, it was recorded in one person's care plan that their mood could change quickly and the person could become verbally aggressive. However, there was no explanation about what action staff should take when this occurred. Another person's care plan contained a nutritional risk assessment that assessed the person as "low risk" of not eating. However, this person had a liquidised diet and relied on the staff for support to eat. Their care plan was not reflective of the care and support they were receiving.

People who had a diagnosis of diabetes did not have care plans relating to the associated care and support required, for example optical care and foot care. There was also no guidance about what blood glucose level was appropriate for this person and what action staff should take if it was outside this range.

People's preferences about when they would like to get up and go to bed were not always recorded in people's care plans, so it was unclear how staff were making decisions in line with people's wishes. Some people told us they were asked at 5pm if they would like to get ready for bed. Another person told us, staff started putting people to bed at about 5pm. They went on to tell us they asked to stay up until about 9pm as they liked to watch television. We spoke with the registered manager about this, she told us staff should only help people into their nightwear on the request of the person, and she was not aware of any staff who did otherwise.

People who required monitoring to maintain their skin integrity were not effectively supported to minimise the risk of pressure ulcers. Documentation was inaccurate and inconsistent. For example, people who needed to be re-positioned in bed did not always receive this care when it was required. One person's care plan stated they were at "very high risk" and required re-positioning every three to four hours. This person had not always been assisted as required and records showed gaps of five to six hours. The registered manager confirmed there were no monitoring systems in place to check if staff were doing what was required.

People's nursing care was not always being consistently documented in their care records and was being recorded in different places. This meant people's care plans were not being kept under appropriate review, resulting in the risk of people's needs not being met. For example, care records for one person had not been fully completed. The person had had an investigation and a swab had been sent off for examination. However, the outcome of the investigation had not been recorded, but additional nursing records showed antibiotics had been prescribed.

Care plans were not always in place and did not always meet people's needs and preferences. Care plans were not effectively reviewed and reflective of the care being delivered. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could participate in organised social activities three days per week, one person told us,

"I love it when we have a singer come along; I've got a good voice". On the day of our inspection people participated in a game of dominoes facilitated by the activities

Requires improvement

Is the service responsive?

coordinator. The activities co-coordinator made the game interesting for people by her engagement and enthusiasm and involved everyone in the game. One person had a hearing impairment, so she adapted her communication by displaying the number of dominoes on her fingers. On the second day of our inspection, people sat in the lounge with the TV on in the background or in their bedrooms which meant some people had very little to occupy their time.

People could raise concerns and complaints. People told us they would speak with the registered manager and felt confident action would be taken. The service had a complaints policy in place which was made available to people and their relatives. The complaints policy was not in a suitable format for people living with dementia, as some people were unable to understand the written words. The registered manager handled complaints and showed as an example of how they had responded to a complaint; this had involved arranging a meeting with the person and their family to find a solution.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in November 2014 we told the provider to take action to make improvements to how they ensured people consented to their care, how the quality of the service was monitored, and how records relating to people's care were documented and kept confidential. Improvements were also required to ensure the management of medicines was safe, people's human rights were protected by the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards, training and supervision of staff was undertaken, safe recruitment process were followed, and systems were in place to protect people from avoidable harm or abuse. At this inspection we found the provider had made some improvements, however further improvements were required.

People did not always receive a high standard of quality care because the provider did not have effective monitoring systems and processes in place in respect of the planning of people's care, meeting people's individual needs, keeping people safe, and ensuring people's human rights were protected.

The systems in place to assess and monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had been unable to effectively manage the service because they had been working as a nurse to cover vacant shifts. The registered manager was open and transparent about the difficulties they had been facing, and admitted failings were down to not having enough time to carry out managerial duties. The registered manager also told us they felt the service had not moved forward since our last inspection. The registered manager explained the provider had been supportive over the phone; but they had not received appropriate onsite support and supervision. We spoke with the provider about the findings of our inspection and expressed our concerns about the sustainability of the current management arrangements and the impact on people. The provider told us because of a difficulty recruiting nurses this had had an impact. They explained there were four nurses who had applied and were going to be interviewed shortly, which they felt would make a difference. The provider told us they were supportive of the registered manager.

The provider asked the registered manager on a monthly basis for a report about the service, to help ensure he had an overview of what was happening within the service. The provider had recently asked for this report to include audits of aspects of care delivery, such as tissue viability, care planning and infection control. However, these tools were yet to be provided and introduced.

People spoke positively about the registered manager and told us, "The manager is lovely in fact they're all lovely", and "The girls and manager are lovely and very attentive". Staff felt the service was well led and told us, "She is lovely….very approachable", "She will go above and beyond", "It's the best home I've worked in" and "she understands what staff need on a daily basis". Some staff told us they felt the registered manager was not supported by the provider.

People and staff were being encouraged to provide feedback about the running of the service, as residents meeting were being introduced.

The registered manager had notified the Commission of significant events which had occurred in line with their legal obligations. For example, expected and/or unexpected deaths. The outcome and ratings given by the Commission of the provider's last inspection had been displayed in line with regulations.

The service was underpinned by a number of policies and procedures, made available to staff. The registered manager had been asked to review policies in line with changing regulations and to ensure they were specific to the care home. However, the registered manager told us this was a big task and they had not had the time. There was a whistleblowing policy in place which protected staff should they make a disclosure about poor practice and staff told us the registered manager had acted in the past, when they had raised concerns about staff conduct.

The registered manager was open and transparent when working with external professionals; they listened to advice and implemented changes as required.

The registered manager had apologised to people when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (2) (3) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans were not always in place and did not always meet people's needs and preferences. Care plans were not effectively reviewed and reflective of the care being delivered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments were not always in place as necessary, updated, and reviewed effectively. Risk assessments were not always reflective of people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People told us there were not always enough staff to meet their needs. There were not sufficient numbers of nursing staff deployed which impacted on the management of the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems in place to assess and monitor the quality of service people received were not effective. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulations 17 (1) (2) (a) (b) (c) (e).

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 9 December 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's mental capacity was not always being assessed. The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not being followed. Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 9 December 2015.